Dental Insurance

Dental and Dental Plus Table of Contents

Introduction

Keeping your teeth healthy is important to your overall health. That is why we offer the State Dental Plan and Dental Plus, a supplemental dental program. To participate in Dental Plus, you must be enrolled in the State Dental Plan, and you must cover the same family members under both plans.

State Dental Plan
The State Dental Plan offers these levels of treatment: diagnostic and preventive, basic, prosthodontics and orthodontics. They are described on page 96. The benefit for orthodontics is limited to a $1,000 lifetime benefit for each covered dependent child under age 19.

The maximum yearly benefit for the State Dental Plan alone is $1,000 for each subscriber or covered dependent. The State Dental Plan deductible is $25 annually for each subscriber or covered dependent who has dental services under Class II or Class III. The deductible for family coverage is limited to three per family per year, or $75.

Once you enroll in the State Dental Plan or Dental Plus, you may not drop that coverage until the next open enrollment period, which will be in October 2009, or until you become eligible to change your coverage due to a special eligibility situation.

Dental Plus
Dental Plus covers the first three levels of service at the same percentage as the State Dental Plan. However, the allowed amount is higher. **Dental Plus does not cover orthodontics.**

Under Dental Plus, the plan's payment for a covered service is the lesser of the dentist's charge or the covered percentage of the Dental Plus allowed amount.

This means you may only be responsible for any applicable deductible and coinsurance amounts. If your dentist charges more for covered services than the Dental Plus allowed amount, **you will be responsible for paying the difference (plus deductibles and coinsurance)** unless your dentist has agreed to accept the Dental Plus allowed amount.

The Employee Insurance Program (EIP) offered agreements to all South Carolina dentists to accept the lesser of their usual charge or the Dental Plus allowed amount. To find the list of dentists who have accepted the agreement, go to the EIP Web site, www.eip.sc.gov:

- Select "Links," and then "State Dental Plan/Dental Plus."
- Click on "BlueCross BlueShield of SC."
- Under "Find a Doctor," select "South Carolina." Under "Healthcare Professional Type, select "Dentists."
- Under "Select a Health Plan," choose "State Dental Plus."
- Under "Select a Specialty," you can choose either "Dentist" or "Oral Surgeon."

If your dentist has not accepted EIP's agreement, your benefits under Dental Plus will not be reduced. However, you will be responsible for the difference between your dentist's charge and the Dental Plus allowed amount plus deductibles and coinsurance.

The maximum yearly benefit for a subscriber or a dependent covered by **both** the State Dental Plan and Dental Plus is $2,000. There are no additional deductibles under Dental Plus.

BlueCross BlueShield of South Carolina is the third-party administrator for the State Dental Plan and Dental Plus. Its address is P.O. Box 100300, Columbia, SC 29202-3300. Customer Service can be reached at 888-214-6230. The fax number is 803-264-7739.

Your Dental Benefits at a Glance

Not all dental procedures are covered. Reimbursement is based on the lesser of the dentist's actual charge or the plan's allowed amount. Please see page 97 for more information.

Class	Services Covered	Plan	Yearly Deductible	Percent Covered	Maximum Benefit
I Diagnostic and Preventive	Diagnostic and preventive procedures Cleaning and scaling of teeth Fluoride treatment Space maintainers (child) Emergency pain relief X-rays	**State Dental Plan alone**	None	100% of allowed amount	$1,000 per person each benefit year combined for Classes I, II and III
		with Dental Plus	None	100% of allowed amount or actual charge	$2,000[2] per person each benefit year combined for Classes I, II and III
II Basic Benefits	Fillings Simple extractions Oral surgery Surgical extractions Preparation of mouth for dentures Periodontal procedures	**State Dental Plan alone**	$25 per person. If you have services in Classes II and III, you pay only one deductible. Limited to three per family per year.	80% of allowed amount	$1,000 per person each benefit year combined for Classes I, II and III
		with Dental Plus	No additional deductible	80% of allowed amount after State Dental Plan deductible is met	$2,000[2] per person each benefit year combined for Classes I, II and III
III Prosthodontics	Onlays Crowns Bridges Dentures Repair of prosthodontic appliances	**State Dental Plan alone**	$25 per person. If you have services in Classes II and III, you pay only one deductible. Limited to three per family per year.	50% of allowed amount	$1,000 per person each benefit year combined for Classes I, II and III
		with Dental Plus	No additional deductible	50% of allowed amount after State Dental Plan deductible is met	$2,000[2] per person each benefit year combined for Classes I, II and III
IV Orthodontics[1]	Limited to covered dependent children age 18 and under Correction of malocclusion Consisting of: diagnostic services (including models and X-rays) Active treatment (including necessary appliances)	**State Dental Plan**	None	50% of allowed amount	$1,000 lifetime benefit for each covered child
		Dental Plus	**Dental Plus does not cover orthodontic services.**	**Dental Plus does not cover orthodontic services.**	**Dental Plus does not cover orthodontic services.**

[1] A subscriber must submit a letter from his provider for the covered dependent children age 18 and under stating that their orthodontic treatment is not for cosmetic purposes for it to be covered by the State Dental Plan.

[2] $2,000 is the maximum yearly benefit an individual may receive when enrolled in both the State Dental Plan and Dental Plus.

CLAIM EXAMPLES (USING CLASS III PROCEDURES)

Under the State Dental Plan and Dental Plus, Class III dental benefits, prosthodontics, are paid at 50 percent of the allowed amount after the $25 deductible is met. The table below illustrates how the two plans work together using a crown (resin with predominantly base metal) as an example.

Dentist's charge	**$680**
State Dental Plan allowed amount	**$349**
State Dental Plan payment (50% of the allowed amount)	**$174.50**
Subscriber enrolled only in the State Dental Plan pays	**$505.50**
Dental Plus allowed amount	**$686**
Total payment for subscriber enrolled in State Dental Plan and Dental Plus (The Dental Plus payment is 50% of the dentist's charge or 50% of the allowed amount, whichever is less)	**$340** (This includes the State Dental Plan payment of $174.50 and the Dental Plus payment of $165.50.)
Subscriber enrolled in Dental Plus pays	**$340**
Additional benefit with Dental Plus	**$165.50**

HOW TO FILE A DENTAL CLAIM

The easiest way to file a claim is to assign benefits to your dentist. Assigning benefits means that you authorize your dentist to file claims for you and to receive payment from the plan for your treatment. To do this, you must show a staff member in your dentist's office your dental identification card and ask that the claim be filed for you. Be sure to sign the payment authorization block of the claim form. BlueCross BlueShield of South Carolina will then pay your dentist directly. You are responsible for the difference between the benefit payment and the actual charge.

If your dentist will not file claims for you, you can file them with BlueCross BlueShield of South Carolina. See page 224 for information on how to file a dental claim.

If you are covered under Dental Plus, BlueCross BlueShield will process your dental claims under the State Dental Plan and then under Dental Plus. You do not have to submit any additional claims. If you are covered under the State Dental Plan and Dental Plus, you will receive an Explanation of Benefits from each plan.

SPECIAL PROVISIONS OF THE STATE DENTAL PLAN

Alternate Forms of Treatment

If you or your dentist select a more expensive or personalized treatment, benefits will be allowed for the less costly procedure consistent with sound professional standards of dental care. BlueCross BlueShield of South Carolina uses guidelines based on usual and customarily provided services and standards of dental care to determine benefits and/or denials.

Examples of when a less costly procedure may apply are:

- An amalgam (silver-colored) filling is less costly than a composite (white) filling placed in a posterior (rear) tooth.
- Porcelain fused to a predominantly base (less expensive) metal crown is less costly than porcelain fused to a nobel (more expensive) metal crown on a tooth.

Pretreatment Estimates

Although it is not required, EIP suggests that you obtain a Pretreatment Estimate of your non-emergency treatment if the charges will exceed $500. To do this, you and your dentist should fill out a claim form before any work is done. The form should list the services to be performed and the charge for each one. Mail the claim form to BlueCross BlueShield of South Carolina, State Dental Claims Department, P.O. Box 100300, Columbia, SC 29202-3300.

To determine the allowed amount for a specific procedure, ask your dentist for the procedure code. You can then call BlueCross BlueShield of S.C. Customer Service at 888-214-6230.

You and your dentist will receive a Pretreatment Estimate form, which will show what part of the expenses your dental plan will cover. This form can be used to file for benefits as the work is completed. Just fill in the date(s) of service, sign the form, have your dentist sign the form and submit it to BCBSSC. Your Pretreatment Estimate is valid for one year from the date of the form. However, the date of service may affect the benefits allowed. For example, if you have reached your maximum benefit when you have the service performed, you will not receive the amount that was approved on the Pretreatment Estimate form.

Emergency treatment does not need a Pretreatment Estimate.

DENTAL SERVICES NOT COVERED

There are some dental services the State Dental Plan and Dental Plus do not cover. The dental plan document, which is available in your benefits administrator's office, lists all these exclusions. The list below includes many of them. You may wish to take it with you when you discuss treatment with your dentist.

General Services not Covered

- Treatment received from a provider other than a licensed dentist. Cleaning or scaling of teeth by a licensed dental hygienist is covered when performed under the supervision and direction of a dentist.
- Services beyond the scope of the dentist's license.
- Services performed by a dentist who is a member of the covered person's family and for which the covered person was not previously charged or did not pay the dentist.
- Dental services or supplies that are rendered before the date you are eligible for coverage under this plan.
- Charges made directly to a covered person by a dentist for dental supplies (i.e., toothbrush, mechanical toothbrush, mouthwash or dental floss).
- Non-dental services, such as broken appointments and completion of claim forms.

- Nutritional counseling for the control of dental disease, oral hygiene instruction or training in preventive dental care.
- Services and supplies for which no charge is made or no payment would be required if the person did not have this benefit.
- Services or supplies not recommended or approved by the attending dentist.
- Services or supplies not recognized as acceptable dental practices by the American Dental Association.

Services Covered by Another Plan

- Treatment for which the covered person is entitled under any Workers' Compensation law.
- Services or supplies that are covered by the armed services of a government.
- Dental services for treatment of injuries as a result of an accident that are received during the first 12 months from the date of the accident are covered under the member's health plan.

Specific Procedures not Covered

- Space maintainers for lost deciduous (primary) teeth if the dependent is age 19 or older.
- Experimental services or supplies.
- Onlays or crowns, when used for preventive purposes or due to erosion, abrasion or attrition.
- Services and supplies for cosmetic or esthetic purposes, including charges for personalization or characterization of dentures, except for orthodontia treatment as provided for under this plan.
- Myofunctional therapy (i.e., correction of tongue thrusting).
- Appliances or therapy for the correction of temporo mandibular joint (TMJ) syndrome.
- Services to alter vertical dimension and/or for occlusion purposes or due to erosion, abrasion or attrition.
- Splinting or periodontal splinting, including extra abutments for bridges.
- Services for these tests and laboratory examinations: bacterial cultures for determining pathological agents, caries (tooth or bone destruction), susceptibility tests, diagnostic photographs and histopathologic exams.
- Pulp cap, direct or indirect (excluding final restoration).
- Provisional intracoronal and extracoronal (crown) splinting.
- Tooth transplantation or surgical repositioning of teeth.
- Occlusal adjustment (complete).
- Services for temporary repair of fractured teeth.
- Rebase procedures.
- Implants and related services, including prosthodontics (crowns and abutments) placed on implants.
- Stress breakers.
- Precision attachments.
- Procedures that are considered part of a more definitive treatment (i.e., an X-ray taken on the same day as a procedure).
- Inlays (cast metal and/or composite, resin, porcelain, ceramic). Benefits for inlays are based on the allowance of an alternate amalgam restoration.
- Gingivectomy/gingivoplasty in conjunction with or for the purpose of placement of restorations.

Limited Services

- More than two of these procedures during any plan year: oral examination, consultations (must be provided by a specialist) and prophylaxis (cleaning of the teeth).
- More than two periodontal prophylaxes. (Periodontal prophylaxes, scaling, root planing and polishing of the teeth, are available only to patients who have a history of periodontal treatment/surgery.) Two periodontal prophylaxes may be performed in addition to two prophylaxes provided above.
- Bitewing X-rays more than twice during any plan year or more than one series of full-mouth X-rays or one panoramic film in any 36-month period, unless a special need for these services at more frequent intervals is documented as medically necessary by the dentist.
- More than two topical applications of stannous fluoride or acid fluoride phosphate during any plan year.

- Topical application of sealants per tooth for patients age 16 and older. For patients age 15 and younger, payment is limited to one treatment every three years and applies to permanent unrestored molars only.
- More than one root canal treatment on the same tooth. Additional treatment should be submitted with the appropriate American Dental Association procedure code and documentation.
- More than four quadrants in any 36-month period of gingival curettage, gingivectomy, osseous (bone) surgery or periodontal scaling and root planing.
- Bone replacement grafts performed on the same site more than once in any 36-month period.
- Additional sites in excess of two bone replacement grafts performed on the same day. (Payment is
- limited.)
- Full mouth debridement for treatment of gingival inflammation if performed more than once per lifetime.
- Tissue conditioning for upper and lower dentures if performed more than twice per unit in any 36-month period.
- The application of desensitizing medicaments is limited to two times per quadrant per year.
- No more than one composite or amalgam restoration per surface in a 12-month period.
- Replacement of cast restoration (fixed crowns, bridges) or prosthodontics (complete and partial dentures) within five years of the original placement unless evidence is submitted and is satisfactory to the administrator that: 1) the existing cast restoration or prosthodontic cannot be made serviceable; or 2) the existing denture is an immediate temporary denture and replacement by a permanent denture is required, and that such replacement is delivered or seated within 12 months of the delivery or seat date of the immediate temporary denture.
- Addition of teeth to an existing removable partial or fixed bridge unless evidence is submitted and is satisfactory to the administrator that the addition of teeth is required for the initial placement of one or more natural teeth.

Prosthodontic and Orthodontic Services

- Prosthodontics (including bridges and crowns) and their fitting that were ordered while the person was covered under the plan, but were delivered or seated more than 90 days after termination of coverage.
- Replacement of lost or stolen prosthodontics, space maintainers or orthodontic appliances or charges for spare or duplicate dentures or appliances.
- Replacement of broken orthodontic appliances.
- Replacement of existing cast prosthodontics unless otherwise specified in the dental plan document.
- Orthodontic treatment for employees, retirees or covered dependents age 19 and older.
- Payment for orthodontic treatment over the lifetime maximum.
- Orthodontic services after the month a covered dependent child becomes ineligible for coverage.

Please note: Dental Plus does not cover orthodontic services.

COORDINATION OF BENEFITS

If you are covered by more than one dental plan, you may file a claim for reimbursement from both plans. Coordination of benefits is a system that allows administrators of both plans to work together to give you the maximum benefit allowed. However, the combined payment will never be more than 100 percent of the allowed amount for your covered dental expenses. For the purpose of coordinating benefits, covered dental expenses are the lesser of the State Dental Plan or Dental Plus allowed amounts or the dentist's charges for the services performed.

For information about how to continue your dental coverage when it ends, please refer to the section on COBRA on page 18.

You will never receive more from your Employee Insurance Program coverage than the maximum yearly benefit, which is $1,000 for a person covered by the State Dental Plan and $2,000 for a person covered by both the State Dental Plan and Dental Plus. The maximum lifetime benefit for orthodontic services is $1,000, and it is limited to covered dependent children age 18 and under.

For detailed information about coordination of benefits, including how to determine which plan pays first, see page 19. If your State dental coverage is secondary, you must send the Explanation of Benefits you receive from your primary plan with your claim to BlueCross BlueShield of South Carolina.

If you have questions, contact BlueCross BlueShield of South Carolina toll-free at 888-214-6230, your benefits office or the Employee Insurance Program.

APPEALS

If BlueCross BlueShield of South Carolina (BCBSSC) denies all or part of your claim or proposed treatment, you will be informed promptly. If you have questions about the decision, check the information in this book or call for an explanation. If you believe the decision was incorrect, you may ask BCBSSC to re-examine its decision. The request for review should be made in writing within six months after notice of the decision by writing to BCBSSC at P.O. Box 100300, Columbia, SC 29219.

If you are still dissatisfied after BCBSSC has reviewed the decision, you have 90 days to request, in writing, that the Employee Insurance Program (EIP) review the decision. If the denial is upheld by EIP, you have 30 days to seek review in the S.C. Administrative Law Court pursuant to S.C. Code Ann. 1-23-380, as amended on July 1, 2006.